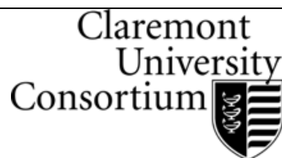

Student Health Services
757 College Way, Claremont, CA 91711
Phone: (909) 621-8222 Fax: (909) 621-8472

H1N1 Flu Vaccine Screening Questionnaire and Consent Form

Part I: Patient Information	**Student ID #**	
Name (Last)	(First)	(Middle)
School	Birth Date Age	Telephone
Address (best address to receive mail)	City	State & Zip

Please answer these questions by initialing the boxes. If the question is not clear, please ask for clarification from the nurse/MA.

Part II: Screening Questionnaire for Immunization	Yes	No	Don't Know
1. Are you sick today?			
2. Do you have any allergies to, eggs or egg products, latex, or thimerosal (a preservative used in vaccines)? Specify:			
3. Have you ever had a serious reaction after receiving a flu shot? Describe:			
5. Have you ever had Guillian-Barre Syndrome?			
6. For Women: Are you pregnant?			

PART III: Flu Vaccine Consent

I have read or had explained to me the information in the vaccine information sheet (VIS) about the influenza vaccine. I have had a chance to ask questions and they were answered to my satisfaction. I believe that I understand the benefits and risks of the vaccine and ask that the vaccine be given to me. I understand that it is recommended that I stay for 15 minutes after receiving the injection to monitor for any adverse reaction to the vaccine.

X____ Date ____________________
Signature of person receiving vaccine or person authorized to make the request (parent or guardian).

PART IV: Administration Record to be Completed by Clinic Staff	
Date Vaccine Administered:	Lot Number: UP002AA
Vaccine Name/Manufacturer: Sanofi Pasteur	Expiration Date: 9 March 2011
Dosage: .5cc IM	Injection Site: R L arm
	Edition Date of VIS Given to Patient: 10/2/2009
Signature and Title of Vaccine Administrator:	